Cultivando La Salud: An Innovation Program Reaching Farmworker Women Transcript

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DR. FERNANDEZ: Thank you, Jon. And thank you, both Jon and Cynthia, for the invitation. Today what I would like to do is share with you a little bit about a program that I've been working on for the last four years in collaboration with some colleagues from the School of Public Health, and also the National Center for Farmworker Health. I'm going to be talking to you, just briefly about Texas colonias, and some of the conditions in the colonias, as well as, specifically, the farmworker community. I do so very humbly, as I am relative newcomer to Texas. And even though I've been working for four years with this community, I realize every day how much more I need to learn.

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But with that, I would like to acknowledge the program team which includes Alicia Gonzalez from the National Center of Farmworker Health. And also my colleague, Guillermo Tortalero- Luna, who is here with us today.

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colonias is a word that was originally meaning simply neighborhoods, or areas of a city. In "Spanglish," colonias refers to primarily Hispanic neighborhoods. And since these neighborhoods are much less affluent than Anglo neighborhoods, typically, the words often connotes poverty and sub-standard housing.

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colonias are unincorporated, unzoned, semi-rural communities, often without access to public drinking water or waste water systems. And many of these colonias that I am going to be talking about today are just south of here. They are in the low Rio Grande Valley area, which is about two hours south of where we are.

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Although there are colonias all around the Texas/Mexico border and other parts of the Mexico/ U.S. border, there are over 1,800 colonias in Texas and they are home to about 350,000 to 500,000 people.

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The Texas Department of Human Services conducted a needs assessment in colonias of the lower Rio Grande Valley. This was some time ago, this was in 1988. But you can find some more information about this -- it is on the web in the colonias fact book. There were 1,200 interviews that were completed. And this was a sampling of residents living in the colonias. What they found was that 65 percent of colonia residents have no health insurance. Sixty-seven percent of those over 18 did not complete high school. Unemployment is 41 percent among those over 16 who aren't in school. Twenty-six percent of households report inadequate heating, 44 percent report problems with flooding, and 15 percent of households report that they don't usually have enough to eat. So we were talking earlier about competing priorities. I think some of these figures underscore that issue when we are dealing with populations living in these areas.

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This is a picture of a colonia that we visited just last week, Colonia Sal si Puedes, which literally means "get out if you can." And when we asked the colonia residents about the name of their colonia, they said that it had to do with the roads. The way that the road was constructed, you really could only go in and out, one way. And once you were in, it was really difficult to find your way out. But they also joked that it sort of is the idea of what they are thinking about their children and their children's future. About getting out or at least, if not getting out, making the colonia a better place for their children.

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A little bit about farmworkers which is the population that we focused on with our project.

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Many Americans don't really think about the issues of farmworkers, and here as we sit and eat our wonderful salads or go to the grocery store and see the vegetables and fruits there, we often don't think about the agricultural system and those people who are really at the center of that system which are these migrant farmworkers and seasonal farmworkers as well. There is an estimated 3.5 to 5 million farmworkers in the U.S. They are mostly Hispanic, but there's also white, African-American, and other farmworkers. In this area in Texas, they are primarily Hispanic, with most being of Mexican origin. There annual earnings are usually well below 100 percent of poverty. The largest home base states are in California, Florida, Texas, and

Washington. And the largest upstream states are North Carolina, Michigan, Colorado and Indiana. What I mean by this is that, for migrant farmworkers, they often leave their homes and travel to follow the crops. And many of the colonias that are in Texas are home base states for these individuals. And so they may go to different parts of the country following the crops, but they come back to their home base. And there is some recent research that shows, actually a colleague of ours from the University of Texas, Sharon Cooper, who has done some work in looking at trying to follow up with farmworkers in Star County, that shows an incredible amount of -- the follow up rate was very high. It indicated that these populations, although they travel throughout the year, are relatively stable, in terms of their home base communities. Approximately 49 percent of farm workers are migrant, and 51 percent are seasonal.

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About 4.2 million migrant and seasonal farmworkers live along the U.S./Mexico border with 370,000 in Texas as I mentioned.

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Most are Mexican born with less than six years of education, and the majority only speak Spanish and earn an average of 5.94 an hour.

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So there's a lot of issues, such as poverty, frequent mobility, low literacy, that are really barriers to access of social services and cost effective primary health care. So as a result, many farmworker families don't use or even think about primary health care. They go to the doctor as a last resort when they are sick and when their home remedies don't seem to be working. So clearly, the farmworker population represents a severely underserved sub-group of border residents.

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Some of the challenges that we knew that we were faced with in just thinking about this project was the fact that there is in many of the communities an unfamiliarity with local resources. Language barriers, transportation, knowledge about their rights. Many farmworkers have -- there are some that are undocumented, but many are not. And some have rights to services and programs that they might not know about. There are problems often with income verification status. In order to qualify for particular programs or to receive benefits in terms of a sliding scale, they need to show what their income is. And that's

often very difficult for farm worker families. Oftentimes, their families are in other states. There is a lack of funds for health care, and there may be an additional need for bi-lingual, bi-cultural services and low literacy materials that may not be available.

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So in meeting these challenges, we knew right away, and just looking at other programs, not necessarily related to cervical cancer, but other programs -- that services have to accommodate their language, culture, and logistic needs, and that examples of programs and strategies that have been found to be effective are ones that include outreach components, peer education programs, and that incorporate bi-lingual and low-literacy materials. And probably most importantly is that these successful programs have all had collaborations between several different agencies and organizations that serve the population.

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We saw a lot of data yesterday -- in fact, I cut out several slides that had data because of that. But just to reiterate -- Hispanics have a considerably higher rate of cervical cancer incidence and mortality.

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And when we look at the lower Rio Grande Valley, in particular, the data from the four most southern counties -- Cameron, Hidalgo, Willacy, and Star, that make up the lower Rio Grande Valley -- show that Hispanics have disproportionately higher incidence and mortality for cervical cancer when compared to non-Hispanics in those counties.

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We're here, as you can see, in Corpus Christi, which is in Public Health Region 11, and Harlingen and those counties that I mentioned are down there where it says the lower Rio Grande Valley.

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This slide shows a comparison of deaths from cervical cancer in the white population in Texas, the Hispanic population in Texas, and then Hispanics specifically in Public Health Region 11. As you can see across different age categories, there are higher death rates in the lower Rio Grande Valley due to cervical cancer.

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When we looked for screening rates or behavior, there was very little to be found. And this, what I'm showing here, is the two slides that

remain after I cut data from our pilot, which was 200 women that we interviewed in colonias in the lower Rio Grande Valley.

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It indicated that almost 30 percent had never had a Pap test and that almost 40 percent had not had a Pap test in the last three years.

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The program that I am going to talk to you about is called Cultivando la Salud, or cultivating health. And it's a replication and dissemination project that's funded from CDC's program, that has funded, I think, 12 other similar projects.

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And the funding was to the National Center for Farmworker Health. Just a little bit about the NCFH. It's a non-profit organization whose mission is to improve the health status of farmworker families through innovative application of human, technical, and information resources. Basically, the NCFH provides technical assistance to and resources to migrant health centers nationwide. And these are community and migrant health centers that receive funding from the Bureau of Primary Health Care.

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The program goal is to increase breast and cervical cancer screening among migrant and seasonal farmworker women, and we are focusing on women 50 and older. And also, to increase the capacity of the migrant and community health centers to carry out a project such as this.

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I am going to just speak briefly about program development.

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And when I say briefly I know you can't see this, but I have some slides that pull it in a little bit closer. This is a process that we undertook in the development of the intervention. It's also a semester long course that I teach, so I'm really going to talk about it in a nutshell here. Basically, intervention mapping is a process for developing theory and evidenced based health promotion programs. And it allows us to take what we know about what the data tell us. What we know about factors influencing health, factors influencing behavior and environment, and methods and strategies that can change those

factors. And taking all of these things into consideration and planning a program in a systematic way.

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So, for this particular project, we began at the needs assessment stage, where we're identifying who are we talking about Who is the at-risk population and what specifically We knew the health problem in this case was breast and cervical cancer. But how does that fit in with their goals, their values, and their quality of life concerns I mean, this is something that came in in our discussion this morning. It was a question that was raised. How do we talk to a community whose worries and concerns about other things so outweigh any discussion we might have about cervical cancer. And we don't really have an answer to that. It's a real challenge. But I think that part of it is making sure that these discussions happen early on, and looking at the broader picture. So, some of what Jon and others have talked about -- if we can tackle this problem, if we can work with you, work with the community with this problem, it can effect and it can help address these other concerns that you as a community also have. So, in addition, I think another point that was made this morning that I think is very important whenever you are talking about needs assessment is not only how bad it is, but also what resources does the community have. And these communities have a tremendous amount of strengths, both in knowledge and experience in forming collaborative relationships. They are incredibly resourceful in trying to figure out how to get care when they may be ineligible for specific programs. And so, it's not only identifying the needs, but also the strengths. The next step is to actually develop these matrices. And I am not going to talk too much about it, except when we look at both evidence and theory in trying to understand or what determinants influence these behaviors, like screening, and these environmental conditions, like these system level factors that we have been talking about, we need to look at them in terms of what do we know What do we know from published literature What do we know from theory What do we know from new data that we are collecting in the community And then once we know this, we are able to develop this matrix of proximal program objectives. They are actually a cross between what we want to happen so what performance objectives or specific behaviors and the determinants of those behaviors. So what happens is that you end up in each cell of the matrix with very specific learning and change objectives that are very closely linked to what the program will actually look like. And it becomes a map. It becomes a way of taking

you to the next step in developing -- well, you'll see.

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Here's the next step. In trying to choose methods and practical strategies that will address those specific objectives. Then we go on to putting together a cohesive program design. And then I want to mention, just briefly, the adoption and implementation plan. Going through this process forces us to consider issues about adoption and implementation during the planning. And so we are considering those issues of the characteristics of a diffusible intervention that Dr. Rogers spoke about yesterday. And we are also considering those factors that are going to influence whether this program is adopted, implemented, and maintained. So we will consider those people, whether they are lay health workers, clinic staff, people making decisions about adoption of the program. What do they need to do, and what are the factors that are going to influence their action In doing that and in doing that in just as careful a way as you do for the target population, you are increasing the probability that your program is not only going to be effective, but it is going to be used and maintained.

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So I'll skip the evaluation, but in this particular program -- it's a five-year program; we're in year-four now. So, I'm not going to talk much about the dissemination, mainly because we haven't done it yet. Although, we do, as I mentioned, have a plan. So the first two years had to do with the development of the program, the implementation strategy, the materials. Also, as I mentioned, some formative research. Pilot testing was in Year Three, and now, just in the last couple of weeks, my colleagues and I have been visiting the sites that are doing baseline data collection for the intervention trial.

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This is just basically a graph figure that is showing the different levels of intervention.

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I mentioned that in that intervention mapping process, we are looking not only at those factors that are influencing behavior, but also what's going on in the environment that may facilitate -- or what can happen in the environment that can facilitate these changes.

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And so that translates to a number of different intervention

components focused at various levels in the community. The farmworker community, lay health advisors, and also those decision makers and health center staff.

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I'm going to talk about the program components. Basically there is a training component. It includes training of clinic staff by the National Center for Farmworker Health, training of promotoras by the clinic staff, and then on- going technical assistance by NCFH. When we developed this program, we knew that we wanted it to be a program that any clinic could take and implement on their own, so that they wouldn't be relying upon the National Center for Farmworker Health to train their promotoras anytime they wanted to start a program or anytime they had a new promotora. And so this was the mechanism by which the clinics thought it would work best, and we are testing now to see if it does. Then there is the implementation of the intervention, which includes door-to- door outreach in farmworker areas. Group presentations and one-on- one contacts. Referrals to breast and cervical cancer screening providers, and follow up. And these are largely implemented through the lay health workers or promotoras. And then, of course, an evaluation component.

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We developed what's called a replication package. And this was something that was for all of the programs that were funded by the CDC. And this particular program was that this was one of the things that we needed to develop. And the replication package included a program manual, a training curriculum, and a tool box.

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The program manual is basically a how to, and it is designed for the clinic staff, the decision maker, whoever that might be. It may be the director of the clinic, it may be the outreach coordinator. It provides background and program description, goals and objectives, the logic model, implementation. It also provides some resources.

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Now, how did we decide what to put into these different components Well, we talked to the people. We talked to the people who would be adopting the program and asked them what do you need. And some of the things that they needed were frankly things that we didn't think they would. For example, they said that they wanted job descriptions. They wanted some assistance in how to recruit and train promotoras.

For the trial, we are working with sites that already have promotora programs in place, but we thought that this might be a program that a clinic may want to adopt, thinking that they are going to put a promotora program in place. So, they also had other information, including evaluation and sample evaluation tools.

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We also developed a breast and cervical cancer training curriculum. And this curriculum was designed for the health center staff to use in training their promotoras. And it included information about breast and cervical cancer, as well as very practical things like teaching methods, the role of promotoras.

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The toolbox is actually the materials that the promotoras take with them in the community. And they include a teaching guide, a flip chart, video, pamphlets, referral information, and audio cassette. Now the referral information -- I just want to expand on that a little bit. One of the things that make this makes this program powerful is not only the fact that we have these materials and these trained promotoras that are delivering these messages, but also they have very specific information about where the women need to go, how to get there, what's covered, what isn't, so that they can provide the most tailored feedback to the woman, given her particular situation and circumstances.

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Within the various materials that I've mentioned, we utilized methods and strategies that -- in during the intervention and mapping process, we are mapped to those specific learning and change objectives. And this is I've mentioned in the discussion, and I'll just mention again here -- this is one of the areas, in terms of intervention development and producing culturally appropriate and relevant interventions, is an area of research that's needed. We know that some programs work, but we don't often know what elements of those programs work or how best to do something. We have some guidelines from past programs and certainly from theory, but there is a lot of guessing that goes on as well. Some of the methods and strategies that we used in the flip chart and video, included role model stories, testimonials, and messages that addressed misconceptions and barriers.

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This is just an example of some of the pages in the flip chart. And for

those of you who may not be familiar with the flip chart, it's basically about this big, and what you see here is what would be on the front, and then on the back is information or short messages, that the health promoter, the promotora, reads or communicates or discusses with the woman. So this addresses -- the first one, up at the top addresses some of the barriers that in the formative evaluation phase we found were important in the population, including "my partner doesn't want me to go," and 'I'm embarrassed; I don't want to go because I am embarrassed." And so, the promotoras, in their training, they are trained to discuss these issues with the women and provide some options for them and some ways of overcoming those. Down below, you see a picture of a woman. And this represents a story on the back side of a testimonial. A woman who, because of regular screening, was able to detect cervical cancer and treat it.

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We're doing an intervention trial, as I mentioned. It's a quasi-experimental design with four matched sites, randomly assigned to intervention and comparison conditions. We have two sites in California and two sites along the border -- Eagle Pass, Texas, and Anthony, New Mexico. The sites in California are in Merced and Watsonville. These are all farmworker communities; they all have migrant community health centers; and they all have breast and cervical early detection program resources within a 20 mile radius.

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One of the things that was critically important, not only in the delivery or the intervention, but also in the collection of data, was to have in every element incorporate principles of participatory research. So this meant, not only getting ideas from the population about what the problems were, what some of the facilitating factors might be, but also involve them in all of the data collection, interpretation, instrument development activities. These are some of our data collectors in California.

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Some of the challenges. There are many challenges in carrying this out. And those include just having to walk the streets, and many times, unpaved streets of these colonias, and going door-to- door and doing interviews. But, I also think that using the interviewers that were often from the very communities or neighboring communities was very useful in terms of getting women to agree to participate.

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Just one of the hazards -- one of the ones that I was particularly distressed by in our last visit.

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But despite that, I think that these data collectors, as well as the promotoras that actually deliver the intervention, are people that are highly motivated. They are people who know the problems, many of the times have experienced them themselves, and are very committed to this effort.

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I'm just going to briefly -- the last few slides. After looking at the information, even though clearly I didn't have this before we planned our program, I was very pleased to see that elements of the program coincided with many of the recommendations that you all made, and the stars there indicate that. I am just going to go through, briefly, some of those.

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First of all, collaboration and partnerships. I made the point that, in our discussion earlier, that when we look at the map, the concept map, and we look at the ratings, we saw that high-risk and underserved was very high. Everybody thought that that was very important. And then collaboration and partnerships was sort of lower on the list. And understanding that it doesn't mean it is not important, but relatively less. However, we didn't really talk about the relationship between these categories. With the main point being that in order to reach high risk women, we have to have collaboration and partnership. So even though it may be at a lower level in terms of importance, it's also necessary in order to do the thing that we rated as the highest importance. So that's a recommendation I guess I have, and since I'm here at the mic, I can make it -- is to look at the relationships between those. So, the collaborations in this particular project included the University of Texas Health Science Center at Houston. We are also collaborating with our new School of Public Health in Brownsville getting some support from them -- The National Center for Farmworker Health, and local communities. And I want to stress the importance of that.

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Targeted public education and communication. I think we provided effective intervention models in terms of utilizing the promotora

model. Distributed county-specific educational information. That includes the information about the availability of screening. So as I mentioned, very specific information about where a woman could go and about how she could get there and what would happen when she got there in terms of cost was very important in facilitating access. Working with other health education initiatives and non-traditional partners to educate about cervical cancer issues. I think that the National Center for Farmworker Health brought a lot to this project in terms of there experience with other problems. And then promoting the dissemination of information through rural community educators.

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Culturally appropriate education and communication development of bi-lingual and multi- lingual education materials and here at the bottom is an example. On one side it is in Spanish. On the other side, it's in English. From the flip chart. And also, something that a couple of people have mentioned. Featuring survivors. I think that's very powerful, using these. We've talked about the role of stories and what role they can play in terms of motivating policy makers. They also play an incredibly important role in terms of motivating women to make behavior changes, particularly if women identify with those models.

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Culturally appropriate education and communication. Train lay leaders -- here are just a few pictures of our training that we conducted in Brownsville. Folks from all of the four sites came to this training. And the reason we did it in Brownsville is so that they could actually practice in a real colonia. And again, obviously develop interventions that are culturally sensitive to Hispanic populations on the border.

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Improve health care training and work force. I will say that in this particular project, there is less of a focus on this, primarily because of a lack of resources to focus on it. However, the clinics that are buying in and adopting this program are encouraged to focus on issues of encouraging providers to make these recommendation.

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And then research on screening, diet, and diagnosis, and I think that's in treatment, but it's hidden in there somewhere. We were certainly in the pilot, and also in our baseline, looking at the target groups attitudes, beliefs, and values about screening and treatment. And we are also looking at the availability of both screening and treatment

services.

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Surveillance and monitoring. Determining why women in low income, rural communities are not obtaining screening. This also is, I think, a picture from -- yes, Sal si Puedes (phonetic). This was Sal si Puedes and this is one of our interviewers during an interview with an older woman while her son is in the back making the wreaths of the peppers. And this -- I think it is very important for us to challenge the models that we have of why -- of understanding behavior in terms of looking at . DR. FERNANDEZ: that have been looked at in other populations and sort of have been assumed to be true determinants, and looking at how they fall out with this population. So I think that's very important as well.

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And then finally, reaching high risk and underserved. I am not going to go through each one, but clearly, I think this program is one, probably of many, that are attempting to do this. And hopefully, what I have shared with you has given you some examples of the way that we are trying to do so.